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In The

Supreme Court of the United States

October Term, 1996

MARY FORSYTH, MARIETTA CADE, WILLIE ANDREWS, MARY LOU BUEHLER, HELEN STAVES, RANDOLPH BRATTON, AND SEARLE AUTO GLASS, INC.,

Cross-Petitioners,

v.

HUMANA, INC., AND HUMANA HEALTH INSURANCE OF NEVADA, INC.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

CONDITIONAL CROSS-PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

I. Whether this Court should decide that the appropriate recovery for ERISA health care billing fraud is the equitable disgorgement of ill-gotten gains, where the purported actual damages do not adequately compensate for deterred usage caused by the excessive co-pay, and do not adequately deter the illicit conduct, where this Court has expressly held that equitable relief is the proper remedy for ERISA violations.

II. Whether the premium payor class can recover RICO damages for excessive premium payments due to Humana Health Insurance's false and misleading commercial advertising and SEC statements that promised payors would "share in reduced hospital costs through premium reductions," where the district court ignored the false advertising statements as "nothing more than puffery" in contravention of this Court's previous holding that the validity of a defense of "puffery" is a question of fact that must survive summary judgment.

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OPINION BELOW

The Ninth Circuit Court of Appeals' decision in this case is reported as *Forsyth v. Humana, Inc.*, 114 F.3d 1467 (9th Cir. 1997) (withdrawing and superseding its own decision in *Forsyth v. Humana, Inc.*, 99 F.3d 1504 (9th Cir. 1996)). The District Court's opinion, also entitled *Forsyth v. Humana, Inc.*, is found at 827 F. Supp. 1498 (D.Nev. 1993). The decisions of both courts are included in the petition for certiorari of the Petitioners.

JURISDICTION

The decision upon which Petitioners seek review was entered by a panel of the Ninth Circuit Court of Appeals on May 23, 1997. Humana, Inc. and Humana Health Insurance of Nevada, Inc. (hereinafter, "Petitioners") submitted a Petition for Writ of Certiorari to this Court on August 18, 1997. This Court has jurisdiction to review that decision as stated therein by Petitioners. Cross-Petitioners have also filed concurrently herewith, an Opposition to Petition for Writ of Certiorari. In the event that this Court grants the Petition, Cross-Petitioners bring this Conditional Cross-Petition for Writ of Certiorari pursuant to Rule 12.5 of the Rules of the Supreme Court of the United States.

The Ninth Circuit Court of Appeals exercised jurisdiction under 28 U.S.C. § 1291. The district court had jurisdiction over this Class Action pursuant to 28 U.S.C. § 1331.

STATUTES AT ISSUE

This Conditional Cross-Petition concerns the Employee Retirement Income Security Act ("ERISA") 29 U.S.C. § 1001 et seq., and the Racketeer Influenced and Corrupt Organizations Act (RICO) 18 U.S.C. § 1951 et seq. Relevant portions of ERISA are attached hereto as Appendix A. Applicable provisions of RICO are included within Appendix C of Petitioners' brief.

STATEMENT OF THE CASE[1]

84,000 Nevada citizens and business entities brought this class action suit as a result of billing fraud and false representations in advertisements by their health insurance provider, Humana Health Insurance, Inc,[2] and Antitrust violations by Humana, Inc., owner of a chain of hospitals, including Humana Hospital Sunrise in Las Vegas, Nevada.[3] Humana, Inc., has since merged with Columbia/HCA, who petitioners concede is beneficially interested.

Humana Insurance sold employee group health care insurance policies to the class. The typical policy

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[1] Portions of this Statement of the Case outlining the general background of this litigation are reproduced in the Statement of the Case in Cross-Petitioners' Opposition to Humana's Petition for Writ of Certiorari filed concurrently herewith.

[2] Hereinafter, "Humana Insurance."

[3] Collectively referred to as the "Humana defendants."

was based on an 80%/20% co-pay system by which the insured would pay 20% of any hospital bill incurred at Humana Hospital Sunrise, and the remaining balance would be satisfied by Humana Insurance. In reality, Humana Insurance negotiated a secret 89% discount with Humana Hospital. To conceal this discount, Humana Insurance remitted payment for 80% of the full, non-discounted hospital bill via check to Humana Hospital and, in turn, Humana Hospital sent a "kickback" of approximately 89% of that payment to Humana Insurance through a monthly, inter-company ledger transfer. Accordingly, a hypothetical $1,000 Humana Hospital bill would result in payment of $200 by the patient, and roughly $100 by Humana Insurance, instead of the contractually agreed upon amount of $800. The patient did not receive any part of the secret discount and paid 20% of the full bill.

In the mid-1980's, Humana Insurance launched a television commercial and direct mail campaign targeting thousands of employers who ultimately purchased health insurance, whereby it represented: "Humana is a hospital company, so we can control costs, saving employers and employees money," and "[b]ecause we can control costs, both you and your company can save a great deal of money without the song and dance." SEC disclosures filed by Humana made similar promises, professing that the health insurance plans were "designed to encourage patients to obtain necessary care in Humana hospitals, where savings could be shared with employers and their employees through lower premiums."

In the mid to late 1980's, at the height of this scheme, Humana Hospital Sunrise was the most expensive hospital in Nevada. The State of Nevada ranked first in the United States in hospital profitability. In 1986, Humana Hospital Sunrise experienced a 42.2% return on investment, contrasting sharply with the 10.3% hospital national average. Humana Hospital Sunrise held many health care cost records from 1986-88, charging the highest amount per patient, earning the highest revenue per patient, and realizing an average $1,363.00 profit every time a patient was admitted.

The Cross-Petitioners consist of two classes of insureds: those who made only health insurance premium payments (Premium Payors), and those who also made co-payments for medical treatment (Co-Payors). Together, they asserted claims based on ERISA, RICO, and Section 2 of the Sherman Act. Although the district court granted summary judgment on several aspects of these claims, only two are the subject of this Cross-Petition.[4] No Anti-trust issues are presented to this Court by this Cross-Petition.

A. ERISA

The district court granted summary judgment in favor of the Co-Payor class on a claim for benefits breach of contract under section 1132(a)(1) of ERISA. This relief was proposed by the Humana Defendants. The district court rejected the Co-Payors' argument

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[4] These same two arguments were presented to the Ninth Circuit Court of Appeals for review.

that the proper remedy under ERISA was to impose a constructive trust and compel disgorgement of the secret discount amount. The co-payors argued that the proposed "actual damage" remedy of recovery of excessive co-payments (calculated retroactively) would not adequately compensate the Co-Payors for the hospital usage that had been precluded or deterred by charging the admittedly excessive co-pay nor adequately deter the illicit conduct. The district court, however, held that the proper measure of damages for over-billing the co-pay amount was limited to the amount of the overcharged co-payment. The district court ignored both case law and empirical studies proving that excessive co-payments would have discouraged hospital usage and provided no remedy for this lost benefit, nor did it deter the illicit conduct. The Ninth Circuit panel affirmed this method of calculation, finding equitable relief inappropriate.

B. RICO

The RICO claim is founded upon Humana Insurance's concealment and misrepresentation of the secret discount arrangement with Humana Hospital. Through its various advertising campaigns, Humana Insurance represented to the Premium Payors that the relationship between Humana Insurance and Humana, Inc., spawned savings that would be realized by the payors via reduced premiums. Similar representations were made in Humana's SEC filings. Despite these advertised promises and Humana Insurance's filing of an actuary formula with the State of Nevada that falsely stated different hospital discounts than those actually applied as the basis of the premium, such

savings were never passed on to the Premium Payor class in the form of reduced premiums.

The district court rejected the Premium Payor Class' misrepresentation claim, deeming the advertisements "nothing more than puffery and [lacking] any representations which would indicate how insurance premiums would be calculated." The court concluded that, as puffing, the advertisements "cannot be viewed as the proximate cause of the Premium Payor Class' asserted RICO injury," and granted summary judgment in favor of the Humana defendants. The Ninth Circuit panel agreed with the district court's characterization, ignoring the subjective, fact-based nature of that determination and adjudging the advertising statements "too general to be interpreted as defining any calculation of insurance premiums."

REASONS FOR GRANTING THIS CONDITIONAL CROSS-PETITION

This case presents a shameless example of the predatory nature of a corporate health care system that preys on guileless patients. Health care fraud is recently coming to the forefront of public attention and law enforcement efforts. The United States Attorney General properly characterizes health care fraud as the second biggest criminal problem in the United States next to terrorism. Thomas O'Donnel, *Clinton Enters Fray Over Health-Care Fraud*, DENV. BUS. J., July 18, 1997, at 15B. Health care scams and kickbacks are identified as a major vehicle for the criminal enterprises that pirated as much as 20% of national health care expenditures in 1994 alone. Jay

Greene, *FBI Takes a Bite out of Healthcare Crime*, MOD. HEALTHCARE, Apr. 29, 1996, at 126. "Health care fraud, it appears, is evolving just as rapidly as the medical marketplace,"[5] Julie Johnson, *Managed Care Fraud: To Track Down Crime, Federal Officials Follow the Money Trail*, AM. MED. NEWS, May 20, 1996, at 3, and the present health care fraud crisis is marked by "obvious and deeply disturbing" parallels to the early stages of the savings and loan debacle. Blakey & Perry, *An Analysis of the Myths that Bolster Efforts to Rewrite RICO and the Various Proposals for Reform: "Mother of God -- Is This the End of RICO?,"* 43 VANDERBILT L. REV. 851, 892 n.115 (1990). Thus, the scope of remedial means of combating this widespread problem could not be more timely and important.

Should this Honorable Court grant Humana's Petition for Writ of Certiorari, this Court should grant this Conditional Cross-Petition for Writ of Certiorari to review the decision of the Ninth Circuit Court of Appeals for three compelling reasons. First, the panel's decision not to permit restitutionary disgorgement of ill-gotten gains as the proper remedy

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[5] Health care fraud by Columbia/HCA, which currently owns and manages the former Humana Hospital Sunrise, is one of the highest profiles in the health care fraud line up. One reporter observed, "It is rare to pick up a daily newspaper anymore without seeing a news account about possible health-care fraud at Columbia/HCA Healthcare Corp. . . ." *Two Big For-Profit Hospital Chains Face Consumer Foes*, PITT. POST-GAZETTE, Aug. 5, 1997, at E1.

for these ERISA violations is wrong because the excessive co-pay that was actually charged discouraged usage. The Co-Payors will, in fact, receive no compensation for this significant damage.

Second, limiting ERISA remedies to theoretical actual damages permits wrongdoers to retain their ill-gotten gains and encourages recidivism. If you steal "it" and you are caught, all you have to do is return "it" - you keep the illicit profits. A restitutionary formula for ERISA-violative health care billing fraud damages that compels disgorgement of illicit profits would extract the incentive from the wrongdoing, consistent with the remedial aims of the statute. This is all the more true where there is no compensation for the deterred hospital usage caused by the excessive co-pay.

Third, the district court's assessment of Humana Insurance advertisements as "nothing more than puffery" amounted to an invasion of the province of the jury in plain contravention of this Court's previous decisions recognizing the subjective, fact specific character of such issues. The advertisements must be read in the context of the SEC filings, which clearly conceded that use of Humana hospitals would yield savings which would "be shared with employers and their employees through lower premiums." The Ninth Circuit panel affirmed the district court's improper assessment of these advertisements. Permitting this error to go uncorrected creates disharmony with relevant precedent and affronts the Seventh Amendment.

A. ERISA Disgorgement

The decision of the Ninth Circuit panel affirming the district court's refusal to permit Cross-Petitioners to obtain a restitutionary remedy was simply wrong and ignores this Court's decision in *Varity Corp. v. Howe*, 116 S. Ct. 1065, 134 L. Ed. 2d 130 (1996), which expressly held that equitable relief is appropriate to remedy ERISA violations where fiduciaries do not act "solely in the interests of the participants and beneficiaries." Moreover, the panel's decision overlooks the deterrent intent of the ERISA statutes and permits the wrongdoers merely to return what they stole and retain their ill-gotten gains, inviting recidivism and sending the message that the judiciary encourages the proliferation of fraudulent health care schemes. The decision also ignores salient case law from this Court and the Courts of Appeals that recognizes the importance of disgorgement remedies in such analogous concerns as anti-trust, securities, commodities, and racketeering.

1. The panel's decision conflicts with salient precedent recognizing that equitable disgorgement is mandatory to deter fraudulent activity.

Humana Insurance violated its duty under section 404(a)(1) of ERISA by attempting to save Humana money at the expense of plan beneficiaries. Under these facts, the lower courts' determination that equitable remedies were not available to the Co-payor class expressly conflicts with this Court's important decision in Varity and various decisions from other Courts of Appeals. The total amount of secret

hospital discounts that Humana Insurance got for the 1985 - 1988 class period equals $49,440,000.00. Assuming a 40% average hospital discount provided to other large insurers, the Co-Payors seek to disgorge the monetary differential between the average large insurer discount and the 89% discount; $22,220,000.00, excluding interest. Humana Insurance convinced the district court to let it keep the $22,220,000.00 in excessive discounts by offering to return a supposed equal 89% discount to some of the Co-Payor Class members that were hospitalized. As set forth *infra*, the ERISA remedy approved by the lower courts is a make-shift creation that does not and can not fully compensate even the hospitalized Co-Payors because it provides no compensation for deterred hospital usage.

More importantly, the lower courts erred in adopting this as "a more appropriate remedy" when disgorgement is, in fact, mandatory under Section 1109(a) for breach of fiduciary duty, even absent "actual damages." The Ninth Circuit decision conflicts with its own precedent and that of other circuits that hold disgorgement is mandatory. In *Amalgamated Clothing & Textile Workers Union, AFL-CIO v. Murdock*, 861 F.2d 1406 (9th Cir. 1988), a Ninth Circuit panel held that "ERISA § 409(a) [1109(a)] specifically requires a fiduciary to give back to an employee benefit plan any ill-gotten profits he earns through a breach of his duties to the plan." *Id.* at 1416 (emphasis added). Similarly, *Waller v. Blue Cross of Calif.*, 32 F.2d 1337 (9th Cir. 1994), approved disgorgement and held that "plaintiffs need not establish financial loss to bring an action seeking a constructive trust to remedy a breach of fiduciary duty." *Id.* at 1340 n.5. Theoretical actual damages

were not the "more appropriate" remedy for the breach of fiduciary duty. Disgorgement was mandatory.

The disgorgement requirement of Sec. 1109(a) is triggered when the fiduciary makes profits "through use of assets of the plan by the fiduciary . . . ."[6] Humana Insurance's activity was such a triggering event. *Waller*, 32 F.3d at 1341, held that Blue Cross was potentially liable for breaching fiduciary duties in its choice of an annuity provider because the beneficiaries alleged that Blue Cross potentially sacrificed the best interest of beneficiaries to profit by maximizing the reversion of residual plan assets. Similarly, Humana Insurance is liable because it sacrificed the Co-Payors interests by agreeing to co-payment by the Co-Payors on full charges to maximize Humana Insurance's own hospital discount. Applying *Waller*, Humana Insurance got its excessive hospital discounts by using plan assets, i.e., bargaining with the purchasing power of hundreds of group health care plans encompassing 84,000 Nevada residents. In addition, during the class period, 30,597 Co-Payors

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[6] *Leigh v. Engle*, 727 F.2d 113, 122 (7th Cir. 1984) ("*Leigh I*"), *aff'd*, 858 F.2d 361 (1988), held that "[t]he nature of the breach of fiduciary duty alleged here is not the loss of plan assets but instead the risking of the trust's assets at least in part to aid the defendants in their acquisition program. ERISA expressly prohibits the use of assets for purposes other than the best interests of the beneficiaries, and the language of section 1109(a) providing for disgorgement of profits from improper use of trust assets is the appropriate remedy."

used Humana Hospital and made co-payments to it and the hospital collected at least $5 Million (probably more) from these Co-Payors alone. The hospital also got tens of millions more in insurance payments for this hospitalization (funded by the insurance premiums).

Humana Insurance explicitly traded this purchasing power by agreeing to millions of dollars of excessive patient co-payments to Humana Hospital in exchange for the excessive Humana Insurance discount. The exact same paragraph in the contract between the Humana entities sets forth the secret discount agreement for Humana Insurance and the co-payor over-billing agreement for Humana Hospital. Other health care providers did not (and could not) negotiate 89% discounts with Humana Hospital for their share of co-payments because other insurers uniformly passed hospital discounts along to co-payors. Because these other insurers would not sacrifice beneficiaries' interests, they did not obtain the same excessive hospital discounts that Humana Insurance obtained (the other insurers got an average 40% discount compared to the 89% rebate Humana gave itself). Because Humana Insurance used plan assets for purposes other than the best interests of beneficiaries, i.e., to obtain greater hospital discounts for itself, Humana Insurance is liable for disgorgement of the excessive discounts it obtained.

The enormous benefit that Humana Insurance provided its parent (the hospital chain) by feeding it business can not be precisely quantified, but it must have been at least equal to the excessive discount or Humana Hospital would not have provided such

payment for the Co-Payor business. It is undisputed that Humana Insurance was formed as a marketing tool to get patients that would make co-payments on non-discounted charges to the over-priced hospital.[7] Health insurers are not typically established to funnel patients to select hospitals.

The panel below found that Humana Insurance should be allowed to keep the excessive discounts it obtained by bargaining plan assets because the make-shift remedy that Humana concocted and proffered to the lower courts supposedly provided an award of the full contractual damages suffered by the Co-Payors. The panel twice errs. First, illicit profits must be disgorged from the errant fiduciary regardless of whether or not any of the individual Co-Payors are entitled to receive or do receive compensation in addition to that accorded to the plan. This is especially true where the vast majority (90.46%) of the plan beneficiaries (i.e., 127,078 of 140,487) receive absolutely nothing under the creative accounting that Humana used to limit its proposed monetary

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[7] The Humana Capsule conceded: "The intent of the program and basis of the cost guarantee is to increase the utilization of Humana hospital. . . ." Humana Capsule, Vol.16, No. 5, p. 1 (Emphasis added) (CR. 820) A Humana Annual Report explained the "strategy to strengthen the hospital business has been to offer insurance [through Humana Insurance] . . . thereby directing patients into our hospitals. 1988 Humana Annual Report (*Id.*)

compensation.[8] Similarly, the health care plans used to get the excessive discounts get absolutely nothing absent disgorgement.

2. *Disgorgement is the appropriate remedy and it is essential to curtail ERISA violations.*

The wisdom of compelling disgorgement of illicit profits is manifest. Disgorgement or restitutionary measures of damages render the tort "worthless to the tortfeasor." RICHARD POSNER, ECONOMIC ANALYSIS OF LAW, at 209-210 (4th ed. 1992). "The primary purpose of disgorgement is to prevent unjust enrichment regardless of whether any victims are entitled to damages," *United States v. Private Sanitation Indus. Ass'n of Nassau/Suffolk*, 44 F.3d 1082, 1088 n.5 (2d Cir. 1994) (quoting *United States v. Bonanno Org. Crime Family*, 683 F. Supp.

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[8] McClure was a Humana expert. The June 16, 1992 McClure Affidavit that sets forth the damages formula adopted by the district court provides that only 13,409 of 140,487 Co-Payors would receive refunds. (CR 937) As said previously, there are approximately 84,000 beneficiaries of the various plans. The reason that there are 140,487 Co-Payors who used the hospital is that the $1,000 co-payor deductible is calculated on an annual basis and many of the plans extended over part or all of the 1984 through 1988 class period. Hence, some of the 84,000 beneficiaries (or family members) are counted twice because of hospitalization in different years. As McClure explained, "Note: The same insured could be an insured in each of the years involved." (Id.) (Emphasis in original)

1411, 1449 (E.D.N.Y. 1988)), *cert. denied sub nom. Ferrante v. United States*, 116 S. Ct. 50 (1995), and deter future violations of the law. *S.E.C. v. First Jersey Sec., Inc.*, 101 F.3d 1450, 1474-75 (2d Cir. 1996) (underscoring the necessity for disgorgement in combatting securities and RICO violations) *petition for cert. filed*, 65 U.S.L.W. 3799 (U.S. May 23, 1997) (No. 96-1862). Disgorgement deters by eliminating the profit incentive in the wrongdoing, *Hawkins v. Allstate Ins. Co.*, 733 P.2d 1073, 1081 (Ariz. 1987), *cert. denied*, 484 U.S. 874 (1987), and as this Court previously recognized, "[f]uture compliance may be more definitely assured if one is compelled to restore one's illegal gains." *Porter v. Warner Holding Co.*, 328 U.S. 395, 400, 66 S. Ct. 1086, 90 L. Ed. 1332 (1946).

Disgorgement repeatedly has been held a proper remedy in analogous areas of federal regulation. This Court upheld divestment -- a disgorgement-like remedy -- as a proper remedy for antitrust violations in *United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 81 S. Ct. 1243, 61 L. Ed. 2d 318 (1961). Disgorgement is also the standard deterrent remedy to cure violations of securities laws,[9] the Commodities Exchange Act,[10] and RICO, itself.

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[9] *See, e.g., First Jersey Sec., Inc.*, 101 F.3d at 1476; *S.E.C. v. AMX Intern., Inc.*, 7 F.3d 71, 74-75 (5th Cir. 1993); *S.E.C. v. Blavin*, 760 F.2d 706, 713 (6th Cir. 1985); *Janigan*, 344 F.2d at 786-87.

[10] *See Commodity Futures Trading Comm'n v. American Metals Exch. Corp.*, 991 F.2d 71, 78-78 (3d Cir. 1993); *Commodity Futures Trading Comm'n v. British*

See Private Sanitation Indus. Ass'n, 44 F.3d at 1088 (recognizing the broad disgorgement remedy under RICO).

As ERISA pre-empts all parallel state legislation, ERISA remedies essentially provide the only means of combatting fraudulent employee health care practices. Thus, it is even more important that ERISA's remedies be liberally construed to bolster their effectiveness. "There are two considerations relevant to the determination of the appropriate remedy [under ERISA]. First, the interests of the participants and beneficiaries must be protected. . . . Second, the remedy must be designed to efficiently deter breaches." *Brink v. DaLesio*, 496 F. Supp. 1350, 1382 (D. Md. 1980). Although actual damages, as awarded and affirmed by the lower courts in this case, could (*but see infra* section two) make the victim whole, merely compensatory damages permit the wrongdoer to retain his ill-gotten gains and insufficiently deter future, similar violations of the statute. Without disgorgement, ERISA's remedial sails remain partially deflated.[11]

Amer. Commodity Options Corp., 788 F.2d 92, 94 (2d Cir. 1986); *Commodity Futures Trading Comm'n v. Hunt*, 591 F.2d 1211, 1222-23 (7th Cir. 1979).

[11] Clearly, the legislative intent of ERISA and analogous precedent dictates that the lower courts erred in precluding Cross-Petitioners from obtaining restitutionary disgorgement on the egregious showing made in this litigation. That disgorgement might result in a windfall to the victim should not affect the decision

3. The damages assessed by the panel fail to fully compensate the Co-Payors for actual losses.

The Ninth Circuit panel's second error is that the penalty that it assessed does not provide full contractual damages to either Co-Payors that used the hospital or to the Co-Payors that did not get medical treatment for two reasons: (1) the excessive co-payments that were imposed severely discouraged utilization of medical benefits by greatly increasing the Co-Payors' cost of usage; and (2) the data base that Humana used to compute the penalty was hopelessly flawed, contained conceded errors and relied upon gross assumptions that are demonstrably false. As *Varity* held, where "adequate relief for a beneficiary's injury" can not otherwise be obtained, equitable relief is 'appropriate'." 64 U.S.L.W. at 4145.

The lower courts were persuaded to attempt to re-construct the supposed reduced co-payment charges that patients would have paid if they had received the same 89% hospital discount that Humana Insurance negotiated for itself and "refund" the difference as "full compensation." This reconstruction was done years after the fact and based upon incomplete billing records. The fundamental flaw in this approach is that imposition of the excessive co-payment charges discouraged medical usage by imposing higher

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to apply the remedy, for "[i]t is more appropriate to give the defrauded party the benefit even of windfalls than to let the fraudulent party keep them." *Janigan v. Taylor*, 344 F.2d 781, 786 (1st Cir. 1965).

transaction costs on potential patients--depriving the Co-Payors of benefits that can never be fully measured monetarily.

It is axiomatic that increasing the required co-payment decreases utilization of medical benefits.[12] A recent study of health care trends published in the May/June 1997 issue of Health Affairs found that adding a co-payment of only $5 "reduced visits to primary care doctors by 11 percent."[13] Recalculating

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[12] *See Kennedy v. Connecticut Gen. Life Ins. Co.*, 924 F.2d 698, 1479 (7th Cir. 1991) (recognizing that "Co-payments sensitize employees to the costs of health care, leading them not only to use less . . . . "); *Kansas Hosp. Ass'n v. Whiteman*, 835 F. Supp. 1556, 1566 (D. Kan. 1993), *aff'd*, 36 F.3d 1106 (7th Cir. 1994) (observing that "Congress generally approves and even encourages participating states to impose required [Medicare] co-payments . . . as a means of controlling utilization."); *Lacey v. Cohen*, 596 F. Supp. 1010, 1018 (E.D. Penn. 1984), *aff'd*, 774 F.2d 1152 (3rd Cir. 1985) (concluding that "[T]he expert testimony verifies the Commonwealth's postulate that imposition of recipient co-payment decreases the overall utilization of medicaid services. David Chavkin, an individual with extensive experience in the field of public health . . . testified that requiring individuals to meet even a nominal assessment for medically necessary goods and services forces those individuals to economize, and sometimes to forego treatment.").

[13] *Co-Payments for HMO's On the Rise, Study Says; Report Cites Pressure to Keep Premiums Low*, THE WASH.

co-payments at a lower rate using the 89% discount does not provide any compensation for the benefit loss of Co-Payors who declined or moderated their medical benefit usage because of the co-payment over-charges. The lower courts' remedy offers no reimbursement for these lost benefits or for the money that Humana Insurance saved because these patients sought less medical treatment than they otherwise would have requested (saving Humana Insurance from having to pay its 80% share of the discouraged medical benefit usage).

Focusing specifically on the economic barrier an excessive co-pay created to usage, the excessive hospital co-charge would reduce utilization of the medical plans in two fundamental ways. First, by over-charging patients, the Humana entities made the co-payment charges for specific services proportionately greater for each prospective patient than what the patient would have paid. For example, if the listed charge for a tonsillectomy was $2,500, Humana required a co-payment of 20% of $2,500 or $500. Under the 89% discount that Humana now wants to retro-actively pass along, a tonsillectomy would only have cost $275 and the co-pay portion would be 20% of $275 or $55. By demanding $500 as the co-payment charge for this procedure during the 1984 through 1988 class period instead of $55, beneficiaries were obviously inhibited from using medical benefits for themselves or their children in the

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POST, May 4, 1997, at A15; Jon Gabel, *Marketwatch: Ten Ways HMO's Have Changed During the 1990's*, HEALTH AFFAIRS, May/June 1997.

first instance. Again, given that a co-payment of only $5 "reduced visits to primary care doctors by 11 percent,"[14] a $500 co-payment charge is an overwhelming disincentive.

For the average plan beneficiary such as a public school teacher,[15] increasing the required co-payment several hundred dollars could either discourage the beneficiary from getting any medical treatment whatsoever, cause the beneficiary to defer treatment or cause the beneficiary to have less treatment than the beneficiary would otherwise purchase.

Assuming that a typical teacher is paid a gross annual amount of $24,000 (approximately $2,000 a month) and also assuming that the teacher nets 66% of gross pay after withholdings on each check, $1,320 would be a fair approximation of the money such a beneficiary had available as monthly disposable income to pay all living expenses. A $500 co-pay charge as opposed to a $55 co-pay charge would be an extreme disincentive to these wage earners. Because there is no way to determine how many of the 84,000 plan beneficiaries were either discouraged or inhibited

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[14] *See supra* note 13 and accompanying text.

[15] Class Representative Randolph Bratton was a teacher in Clark County, Nevada during the 1984 through 1988 class period and his employer (the Clark County School District) administered the single largest benefit plan in this case, covering tens of thousands of Clark County teachers and their families.

from using medical benefits by excessive co-pay actually charged during the four year class period, it is impossible to fully re-store these plan beneficiaries the value of their lost benefits by re-paying the excessive co-payment for the reduced usage that actually occurred.

The second way the excessive hospital co-charge reduced utilization of medical benefits is that the over-payment took monies away from the plan beneficiary that otherwise could have been available for co-payments for additional hospital treatment. In the $2,500 tonsillectomy example cited above, if the $55 co-payment -- what the panel held should have been the appropriate co-pay figure -- had been charged instead of $250, the plan beneficiary could have made co-payments for tonsillectomies for five family members for $275--roughly the same amount that Humana Insurance over-charged as the co-payment for one single tonsillectomy. Similarly, if a $55 co-pay had been charged for the tonsillectomy operation instead of $275, the plan beneficiary would have had an additional $220 to purchase medical treatment from their individual doctors.

Accordingly, because usage of benefits would obviously have been discouraged by excessive co-pay charges, and because there is no way to determine the total amount of medical treatment that would have occurred if the co-pay charges had been calculated in 1984 through 1988 at the proper amounts, the Ninth Circuit's decision falls significantly short of fully compensating the Co-Payor class and this Court should grant this Conditional Cross-Petition for Writ of Certiorari to decide that a restitutionary remedy is

appropriate to cure such ERISA violations.

B. RICO Puffing

The Ninth Circuit panel's affirmation of the district court's summary holding that the commercial misrepresentations by Humana Insurance that promised that policy purchasers would realize reduced hospital costs were "nothing more than puffery" was simply erroneous and contravenes the teaching of this Court and others that have considered "puffery." Review by this Court is necessary to prevent injustice and the further growth of a mutant branch of a well-settled area of the law.

Traditionally, the jurisprudence of a puffing defense to false advertising claims has always recognized the fact-specific character of all advertising claims and their various defenses, as well as the need that each receive the individual attention of a jury. This Court acknowledged the fact-sensitive nature of such advertisements and defenses as early as 1916 in *United States v. New South Farm & Home Co.*, 241 U.S. 64, 70-72, 36 S. Ct. 505, 60 L. Ed. 890., when it considered whether a farm developer's mail campaign was actionable mail fraud or merely permissible puffing. In *New South Farm,* this Court held:

> Mere puffing . . . is the mere exaggeration of the qualities which the article has; but when a proposed seller goes beyond that, assigns to the article qualities which it does not possess, does not simply magnify in opinion the

> advantages which it has, but invents advantages and falsely asserts their existence, he transcends the limits of 'puffing' and engages in false representations and pretenses.

New S. Farm, 241 U.S. at 71.

Lower courts and legal scholars agree on the proper treatment of statements that may be regarded as "puffery." The courts consistently find that "[w]hether representations made by a seller are warranties and therefore, a part of the bargain, or merely expressions of the seller's opinion, or mere 'puffing,' is almost always a question of fact for a jury's resolution." *Yuzwak v. Dygert*, 534 N.Y.S.2d 35, 7 UCC Rep. Serv. 2d 731, 732 (1988); *accord, PAU v. Yosemite Park & Curry Co.*, 928 F.2d 880, 886-87 (9th Cir. 1991) (reversing district court's holding as a matter of law that statements in brochure were merely puffing); *Downie v. Abex Corp.*, 741 F.2d 1235, 1239-40 (10th Cir. 1984) (stating with regard to puffing that question is whether a rational jury could conclude the representation is an express warranty). Legal commentators, too, repeatedly observe that "whether a statement will be treated as an express warranty or as 'puffing' is a question of fact that is not easily resolved. . . [as] the difference is not always readily apparent. . . . [R]esolution of this issue depends on the facts and circumstances of each case." Scott J. Burnham, *Remedies Available to the Purchaser of a Defective Used Car*, 47 MONT. L. REV. 273, 284 (1986); *see also* Wayne K. Lewis, *Toward a Theory of Strict "Claim" Liability: Warranty Relief for Advertising Representations*, 47 OHIO ST. L.J. 671, 680 & n.63

(1986).

Section 2-313 of the Uniform Commercial Code is itself illustrative of this principle. Under the Code, the task of determining whether an advertisement is puffery "is one for the jury under the general test, or instruction of whether a reasonable person in the position of the buyer would find the statement reliable." 2 UCC SERIES *Sales* § 2-213:03, at 421. As the Code recognizes, "[a]dvertising . . . often presents a close factual question in this regard, though the tendency under the Code seems to be to hold that most advertising rises to the level of an express warranty if the buyer relies on it." *Id.*

The correctness of this view (and thus the error of the panel's decision) is further buttressed by this Court's trilogy of cases defining the role of summary judgment in litigation. The Seventh Amendment preference that a claimant be given the opportunity to have his claims decided by a jury echoes throughout the compendium of this Court's summary judgment decisions. Accordingly, the function of the judge is not to determine the merits of any claim, for that assessment is intended for the fact finders alone. As this Court remarked in *Anderson v. Liberty Lobby*, 477 U.S. 242, 249, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986):

> it is clear enough from our recent cases that at the summary judgment stage the judge's function is not himself to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial.

Summary judgment is only appropriate when, based on "the inferences to be drawn from the underlying facts," viewed in the light most favorable to the non-moving party, no reasonable juror could return a verdict for that party. *Matsushita Elec. Industr. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 587 106 S. Ct. 1348, 89 L. Ed. 2d 538 (1986); *Anderson,* 477 U.S. at 249-50. As various scholars and lower courts have recognized, advertising claims capable of multiple inferences do not fall within the scope of issues proper for summary judgment. *See, e.g.,Opera v. Hyva, Inc.*, 450 N.Y.S.2d 615, 619 (1982); Burnham, *supra* at 284. As such advertisements cannot be so readily compartmentalized, a court may not pluck them from the jury and dismiss them as "mere puffery" without overstepping its role under Federal Rule 56 and contravening this Court's explicit teaching.

Cross-Petitioners recognize, of course, that "puffing" is a defense to a fraud allegation under RICO or otherwise, however, the question of whether an advertising statement crosses the line between puffing and fraudulent misrepresentation is one for the jury, not the court. Accordingly, to prevent the creation of bad precedent, this Court should grant this Conditional Cross-Petition to review the decision of the lower courts and clarify the appropriate role of judge and jury in this important area.

CONCLUSION

For the foregoing reasons, if this Honorable Court grants the Petition for Writ of Certiorari and elects to hear this case, this Conditional Cross-Petition for Writ of Certiorari should be granted.

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APPENDIX

APPENDIX A

(Relevant Statutory Provisions)

Employee Retirement Income Security Act, 29 U.S.C. § 1132(a):

> A civil action may be brought -- (1) by a participant or beneficiary -- (A) for the relief provided for in subsection (c) of this section, or (B) to recover benefits due to him under the terms of this plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan; (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title; (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan . . .